

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**HEALTHY FAMILIES PROGRAM**  
**BUDGET TRAILER BILL**  
**R-3-02**

**FINAL STATEMENT OF REASONS**

In August 1997, the Federal Government established a new program, the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. The purpose of the program is to provide health services to uninsured, low-income children. The program is targeted to serve children whose family's income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The Legislature passed, and the Governor signed AB 1126, resulting in Chapter 623, Statutes of 1997 (AB 1126). Under that law, California has taken the option of both expanding its Medi-Cal Program and establishing a new stand alone children's health insurance program, the Healthy Families Program (HFP). The Department of Health Services (DHS) administers the Medi-Cal expansion through its own regulations. The Managed Risk Medical Insurance Board (MRMIB) administers the HFP. The basic structure of the HFP is set out in regulations approved by the Office of Administrative Law, which established Chapter 5.8 of Title 10 of the California Code of Regulations.

The budget trailer bill, AB 442 (Chapter 1161, Statutes of 2002), directed the Board and the Department of Health Services to implement pre-enrollment procedures into the HFP and the Medi-Cal for Families Program by establishing a streamlined enrollment process from the Child Health and Disability Prevention Program (CHDP). The pre-enrollment (CHDP Gateway) is administered by the Department of Health Services to provide full-scope benefits pursuant to the Medi-Cal Program's no-cost fee-for-service program. The pre-enrollment is funded from Title XIX and Title XXI moneys. The purpose of the CHDP Gateway is to increase access to on-going, comprehensive health, dental and vision care for children, who received periodic health screening and limited health treatment services through CHDP. Beginning July 1, 2003, CHDP conducts a preliminary eligibility review and automatically screens children into either no-cost Medi-Cal or the HFP. These children now have access to complete health, dental and vision services for up to two months through the Medi-Cal no-cost fee-for-service program. Subsequently, the family will have to apply for continued coverage (12 months of eligibility) in Medi-Cal or HFP for their children via the joint Healthy Families/Medi-Cal for Children mail-in application. To allow successful implementation of the CHDP Gateway, AB 442 included the following provisions:

- elimination of retroactive disenrollment when families are disenrolled due to non-payment,

- requirement that applicants must pay arrears for health coverage provided within the prior twelve months, and
- changes to the family contribution sponsor regulations to allow a sponsor to pay monthly premiums for a HFP family for any twelve months of coverage.

In addition, in order to make the changes in AB 442 work, the HFP regulations requiring a six month wait period before a family can re-apply after the family is disenrolled due to non-payment or per an applicant's request have been deleted.

Formerly the regulations mandated that the HFP disenroll a family retroactively after two consecutive months of non-payment of monthly premiums. This meant that if a family did not pay the monthly premium for two consecutive months, disenrollment would occur at the end of the second month of non-payment but the children's coverage would be terminated retroactively back to the last month in which the premiums were paid. This regulation was in place to balance the statutory requirement to collect premiums from HFP families with the need to allow time for collection before disenrolling the subscriber. During these months, the State was contractually obligated to pay one month of the capitated payments to the health, dental, and vision plans. The plans were allowed to collect any costs incurred during the final month from the family. It is necessary to eliminate the retroactive disenrollment regulations to conform to AB 442.

The elimination of the retroactive disenrollment regulations created the need to include regulations to authorize the collection of the previous twelve months of arrears prior to re-enrollment. In these proposed regulations, when a family is disenrolled for non-payment, they will have received two months of health coverage for which the HFP did not receive the premium payments. With the amended regulations on the payment of arrears, the HFP will be able to recoup the premium payment for those unpaid months. The collection of arrears is limited to the twelve months prior to enrollment because the Legislature established a standard time of twelve months away from the HFP to be considered as closure of an HFP account. If a family is out of the HFP for twelve months, they have disconnected from HFP services and are clearly disenrolled.

The family contribution sponsor regulations have been amended to state that the sponsor may make contributions for a family during any twelve month period as required by AB 442. Formerly the regulations stipulated that the family contribution sponsor could make contributions on behalf of a family only in the applicant's first twelve months in the program. The ability to sponsor a family for any twelve month period will give more families access to continued health care.

The six month wait period for families disenrolled per their request was originally established to discourage families from coming into the HFP only when they needed services. The intent of the six month wait period was to eliminate the "revolving door" and to encourage families to receive preventive health care and to have continued

access to health care. We have learned that the HFP families do not use this “revolving door” and most remain in the program for the duration of their twelve months of eligibility. The deletion of the six month penalty for disenrollment due to non-payment or per an applicant’s request is necessary for successful implementation of the CHDP Gateway. If the six month penalty remained in place, a family that uses a CHDP provider would be blocked from enrollment into the HFP during this timeframe. This change helps to achieve the goal of the HFP and the CHDP Gateway which is to ensure children have more continuity in accessing health coverage.

In addition to the regulatory changes made in accordance with AB 442, the Board is including in this package related regulations which make changes required by Federal regulations under Title XXI for the SCHIP which funds the HFP. These regulations, 42 CFR, Parts 431, 433, 435, and 457 became final on January 11, 2001 and further interpret Title XXI. These Federal regulations require continued enrollment in the HFP during the review of an appeal prior to losing coverage. These enrollee protections are consistent with the objectives of the CHDP Gateway because they further insure continuous enrollment while an appeal is in process and they are therefore included in the same package.

Section 2699.6827, Payment of State Supported Services, was added to require that abortions that are not the result of incest or rape and are not necessary to save the life of the mother are to be paid for with State funds only. Federal funds provided to the State under title XXI can not be used to pay for these services. This Subsection and the definition of State Supported Services in Subsection 2699.6500(jj) were added to identify which services are not to be paid for with federal funds. This is necessary to be able to make distinctions in the Board’s contracts with health plans for federally funded services and the new, separate contracts which fund only non-federally eligible abortion services, as required by 42 CFR 457.475.

This statement of reasons is presented in two sections, “Regulation Changes due to the Budget Trailer Bill and the CHDP Gateway Implementation” and “Regulation Changes to Conform to Federal Regulations”, for purposes of clarity.

## **REGULATION CHANGES DUE TO THE BUDGET TRAILER BILL AND THE CHDP GATEWAY IMPLEMENTATION**

### **Article 1. Definitions**

- **Subsection 2699.6500(n)** clarifies the definition of a family contribution sponsor to state that the sponsor is registered with the Program instead of the Board. The definition is further revised to bring it into conformity with Insurance Code Section 12693.17, which was changed in the trailer bill to allow for sponsors to make contributions beyond the initial twelve months. Finally, the reference to this

change taking place with the start date of parental coverage is deleted since the statute now allows for this change prior to the start of parental coverage.

## **Article 2. Eligibility, Application, and Enrollment**

- **Amend Subsection 2699.6600(a) (3):** The cross-reference in this Subsection on the application process is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.
- **Amend Subsections 2699.6600(a) (4) and 2699.6600(a) (5):** These Subsections on the application process are amended to limit payment of arrears to those incurred within the prior twelve months when an applicant reapplies for the HFP. These amendments are made due to budget trailer bill language which amends Insurance Code Section 12693.70.
- **Amend Subsection 2699(c)(1)(Q):** This Subsection, which requires persons for whom application is made, to indicate if they have employer sponsored health coverage, or have had such coverage within the past three months, is revised to delete the term "dependent" from dependent health coverage. The regulations had previously been amended in anticipation of adding parental coverage to the HFP and the program will need to know the employer health insurance status of all applicants when that happens, in order to determine eligibility for the family.
- **Delete Subsection 2699.6600(c)(1)(Z)4:** This Subsection required the applicant to submit a declaration that the applicant is aware that nonpayment may result in disenrollment back to the last period for which the family contribution was made is deleted. This Subsection is amended to conform to the changes to Insurance Code Section 12693.45.
- **Delete Subsection 2699.6600(c) (1) (BB):** This Subsection required the reason for disenrollment if disenrollment occurred within the previous six months. The deletion of the six month penalty for disenrollment due to non-payment or applicant request is necessary for CHDP Gateway pre-enrollment. If the six month penalty was in place, it would hinder the pre-enrollment process by preventing enrollment in the HFP during the six month period.
- **Previous Subsections 2699.6600(c) (1) (CC) through (II):** These Subsections on the application process are renumbered as Subsections 2699.6600(c) (1) as a result of deleting former Subsection 2699.6600(c) (1) (BB) through (HH).
- **Amend Subsections 2699.6607(a) (1) and (2):** The cross-reference to Subsection 2699.6611(d) which requires the subscriber to wait six months before re-enrolling is deleted because Subsection 2699.6611(d) is deleted.

- **Amend Subsections 2699.6611(b) (1):** This Subsection is amended to delete the requirement that subscribers are disenrolled retroactively for non-payment. Language was added to state that subscribers will be disenrolled at the end of the second consecutive month of non-payment. These changes are made due to the deletion of the retroactive disenrollment due to non-payment as required by the changes to Insurance Code Section 12693.45, which was changed in the trailer bill.
- **Amend Subsection 2699.6611(b)(2):** This Subsection is amended to delete the language stating disenrollment for nonpayment will result in the termination of benefits retroactive back to the last calendar month for which the family contribution was made. Language is added to state that termination for nonpayment will take place at the end of the second consecutive month for which the family contribution was not paid. This amendment is made to conform to changes in Insurance Code Section 12693.45, which was changed in the trailer bill.
- **Delete Subsection 2699.6611(b)(3):** This Subsection states that the applicant is financially responsible for services received after disenrollment. This Subsection is no longer necessary due to amendments to Subsection 2699.6611(b)(2). This amendment is made to conform to changes in Insurance Code Section 12693.45, which was changed in the trailer bill.
- **Delete Subsection 2699.6611(d):** This Subsection established the six month waiting period for individuals who are disenrolled due to nonpayment. The deletion of the six month penalty for disenrollment due to non-payment or applicant request is necessary for CHDP Gateway pre-enrollment. If the six month penalty was in place, it would hinder the pre-enrollment process by preventing enrollment in the HFP during the six month period.
- **Former Subsections 2699.6611(e) through (p):** These Subsections on disenrollment are renumbered as Subsections 2699.6611(d) through (o) due to the deletion of Subsection 2699.6611(d). Subsection 2699.6611(e), formerly (d), is revised to be consistent with changes to Subsection 2699.6611(b)(2), which eliminated retroactive disenrollment for non-payment. Adding the term "consecutive" is a post emergency change suggested by the Office of Administrative Law, for greater consistency with (b)(2).

### **Article 3. Health, Dental, and Vision Benefits**

- **Amend Subsection 2699.6705(a) (6):** This Subsection states that co-payments for health benefits shall not be charged if the applicant submits documentation of

American Indian or Alaska Native status. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.

- **Amend Subsection 2699.6715(d):** This Subsection states that co-payments for dental benefits for subscriber children shall not be charged if the applicant submits documentation of American Indian or Alaska Native status. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.
- **Amend Subsection 2699.6717(c):** This Subsection states that co-payments for dental benefits for subscriber parents shall not be charged if the applicant submits documentation of American Indian or Alaska Native status. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.
- **Amend Subsection 2699.6725(e):** This Subsection states that co-payments for vision benefits shall not be charged if the applicant submits documentation of American Indian or Alaska Native status. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.

#### **Article 4. Risk Categories and Family Contributions**

- **Amend Section 2699.6813:** This Subsection states that family contribution payments shall be made unless the applicant is American Indian or Alaska Native. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.
- **Amend Subsection 2699.6813(a):** This Subsection states that family contribution payments shall not be required for two months pending submission of documentation of American Indian or Alaska Native status. The cross-reference is changed from 2699.6600(c) (1) (GG) to (FF) due to renumbering.
- **Amend Subsections 2699.6815(e) and (f):** Language is added to clarify that subscribers will be disenrolled if contributions are not paid for two consecutive months and that disenrollment will occur at the end of the second consecutive month for which the family contribution is not made. Language indicating disenrollment will be retroactive to the end of the month in which family contributions were paid in full is deleted. These changes are made due to the deletion of the retroactive disenrollment due to non-payment as required by the changes to Insurance Code Section 12693.45, which was changed in the trailer bill.
- **Amend Subsection 2699.6819(c):** This Subsection is amended to state that the family contribution sponsor may sponsor the family for any twelve month period. The family contribution sponsor is no longer limited to sponsoring a family for the first twelve months. This definition is revised to accurately reflect the changes to

family contribution sponsor changes made in a prior regulation change. These changes are made to bring it into conformity with Insurance Code Section 12693.17, which was changed in the trailer bill.

## **REGULATION CHANGES TO CONFORM TO FEDERAL REGULATIONS**

The Board is including, in this package, regulation changes required by Federal regulations for the State Children's Health Insurance Program which funds Healthy Families. These changes reflect the goal of the CHDP gateway which, is to provide access to comprehensive health coverage and maintain on-going care for children.

### **Federal Regulations**

42 CFR, Part 457, Section 457.1170 requires the State to ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing. 42 CFR, Part 457, Section 457.1180 requires the State to provide enrollees and applicants timely written notice of any determinations which are subject to review under 457.1130. The notice must include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

Under Federal Law (42USC Section 1397ee(c)(5) ) federal funding may not be used to pay for abortion services except those that result from incest or rape or services necessary to save the life of the mother. 42 CFR, Part 457, Section 457.475 restates these and requires that states in which managed care entities provide abortions at state only expense, as does California, provide the services under a separate contract, using non federal funds.

### **Reason for Changes**

Under California statute, Insurance Code Sections 12693.86 and 12693.87(b), an appeal of a disenrollment can be filed with the MRMIB and the MRMIB has thirty days to process the appeal and make a determination. However, the HFP regulations do not describe the appeal process explicitly nor do the HFP regulations allow for the program to provide continued enrollment in the program while an appeal is being processed.

The addition of Section 2699.6612, Appeals, is necessary to conform to the new federal requirement of continued enrollment pending an appeal. The inclusion of the continued enrollment process in the regulations without any description of the appeal process would be confusing and unclear because there would be no context for understanding the continued eligibility rule. The new language in the Appeals Section provides the

necessary framework for the continued enrollment regulations to be understood by the reader and to be appropriately applied.

Sections on “State Supported Services” are added to conform to Federal Regulations to ensure only non-Federal funds are used to pay for abortion services.

### **Article 1. Definitions**

- **Adopt new Subsection 2699.6500(jj):** The term “State Supported Services” is added. This term means abortions that are not the result of incest or rape and are not necessary to save the life of the mother. This definition is added to clarify which services must be covered with state funds. The Board has selected this defined term to refer to non-federally funded abortions in its separate health plan contracts for state funded abortion services.
- **Amend Previous Subsections 2699.6500(jj) through (nn):** These Subsections on definitions are renumbered as Subsections 2699.6500(kk) through (oo) as a result of adding Subsection 2699.6500(jj).

### **Article 2. Eligibility, Application, and Enrollment**

- **Amend Subsections 2699.6611(c)(1) through (c)(4):** These Subsections on the requirements of disenrollment notices, are changed for clarity and cite each section as a complete sentence rather than one sentence listing all requirements.
- **Amend Subsection 2699.6611(c)(4):** This Subsection is amended to require written disenrollment notices to include the applicant’s right to request continued enrollment when filing an appeal. This amendment is made to comply with Federal regulation 42 CFR, Part 457, Section 457.1170.
- **Adopt Section 2699.6612 Appeals:** This Section is adopted to establish the appeals process which includes the outline for continued enrollment when filing an appeal as stated in Subsection 2699.6611(c)(4). This Section is added to comply with federal regulatory requirements (42 CFR, Part 457, Section 457.1170). The authority for this Section is Insurance Code Section 12693.85, 12693.86, 12693.87, and 12693.89.
- **Adopt Subsection 2699.6612(a):** This Subsection establishes that program decisions listed in Subsections (a)(1) through (a)(3) may be appealed to the board. Authority for this regulation is Insurance Code Section 12693.85.
- **Adopt Subsection 2699.6612(a)(1):** This Subsection states that a program decision that an individual is not qualified to participate or to continue

participation in the program may be appealed. Authority for this regulation is Insurance Code Section 12693.85(a).

- **Adopt Subsection 2699.6612(a)(2):** This Subsection states that a program decision that an individual is not eligible for enrollment or continued enrollment in the program may be appealed. Authority for this regulation is Insurance Code Section 12693.85(b).
- **Adopt Subsection 2699.6612(a)(3):** This Subsection states that the effective date of coverage may be appealed. Authority for this regulation is Insurance Code Section 12693.85(c).
- **Adopt Subsection 2699.6612(b):** This Subsection requires the appellant to submit the appeal in writing and within sixty calendar days from the date of the notice of the decision. Authority for this regulation is Insurance Code Section 12693.86(a).
- **Adopt Subsection 2699.6612(c):** This Subsection outlines the appeal review process. Authority for this regulation is Insurance Code Section 12693.86(a). Authority for this regulation is Insurance Code Section 12693.87(a).
- **Adopt Subsection 2699.6612(c)(1):** This Subsection describes the first level appeal process the program must follow. This includes the requirements that the program make a determination within thirty calendar days of receipt of the appeal, notify the applicant of the decision in writing, and provide second level appeal rights. Authority for this regulation is Insurance Code Section 12693.87(b).
- **Adopt Subsection 2699.6612(c)(2):** This Subsection describes the second level appeal process the appellant and the program must follow. Appellants must file the second level appeal with the Executive Director within thirty calendar days of the date of the first level decision notice. The program shall notify the appellant of the program's decision in writing and provide administrative hearing appeal rights. Authority for this regulation is Insurance Code Section 12693.87(b) – (e).
- **Adopt Subsection 2699.6612(c)(3):** This Subsection describes the administrative hearing process. The administrative hearing will be conducted by an Administrative Law Judge employed by the Office of Administrative Hearings. The appellant is required to file the administrative hearing request with the program within thirty calendar days of receipt of the second level appeal decision notice. Authority for this regulation is Insurance Code Section 12693.89(a).

- **Adopt Subsection 2699.6612(d):** This Subsection establishes that an appeal filed by an applicant must include the items listed in Subsections (d) (1) through (d) (5). Authority for this regulation is Insurance Code Section 12693.86(b).
- **Adopt Subsection 2699.6612(d)(1):** This Subsection requires the appellant to include a copy of the decision being appealed, or a written statement of the action or failure to act that is being appealed when filing an appeal. Authority for this regulation is Insurance Code Section 12693.86(b)(1).
- **Adopt Subsection 2699.6612(d)(2):** This Subsection requires the appellant to include a statement describing the issues that are being disputed. Authority for this regulation is Insurance Code Section 12693.86(b)(2).
- **Adopt Subsection 2699.6612(d)(3):** This Subsection requires the appellant to include a statement describing the program statute, regulation, or other written representation of program policy that the program or the board violated. Authority for this regulation is Insurance Code Section 12693.86(b)(3).
- **Adopt Subsection 2699.6612(d)(4):** This Subsection requires the appellant to include a statement of the resolution being requested. Authority for this regulation is Insurance Code Section 12693.86(b)(4).
- **Adopt Subsection 2699.6612(d)(5):** This Subsection requires the appellant to include any other relevant information. Authority for this regulation is Insurance Code Section 12693.86(b)(5).
- **Adopt Subsection 2699.6612(e):** This Subsection is added to allow the appellant to request continued enrollment while the appeal is being processed. Enrollment in the program will continue until a determination is made. Authority for this regulation is 42 CFR, Part 457, Section 457.1170.
- **Adopt Subsection 2699.6612(e)(1):** This Subsection limits continued enrollment to first level appeals as described in Subsection 2699.6612(c)(1). Authority for this regulation is 42 CFR, Part 457, Section 457.1170.
- **Adopt Subsection 2699.6612(e)(2):** This Subsection requires the request for continued enrollment to be written and filed with the program within fifteen calendar days of the date of the notice of the decision being appealed. Authority for this regulation is 42 CFR, Part 457, Section 457.1170.
- **Adopt Subsection 2699.6612(e)(3):** This Subsection requires the appeal that requests continued enrollment to meet all other requirements of Subsection 2699.6612. Authority for this regulation is 42 CFR, Part 457, Section 457.1170.

#### **Article 4. Risk Categories and Family Contributions**

- **Adopt Subsection 2699.6827 Payment of State Supported Services:** This Subsection is added to require that abortions that are not the result of incest or rape and are not necessary to save the life of the mother are to be paid for with State funds only. Federal funds provided to the State under title XXI can not be used to pay for these services. This Subsection and the definition of State Supported Services in Subsection 2699.6500(jj) are added to identify which services are not to be paid for with federal funds. This is necessary to be able to make distinctions in the Board's contracts with health plans for federally funded services and the new, separate contracts which fund only non-federally eligible abortion services.

#### **COMMENTS AND RESPONSES**

The Notice for these regulations was published on August 22, 2003 and a Public Hearing was held on October 8, 2003. No oral, written or electronic comments were received for these regulations.

No oral, written or electronic comments were received from the Office of Small Business Advocate or the Trade and Commerce Agency.

#### **DATA, STUDIES, AND REPORTS RELIED UPON**

MRMIB did not rely on any specific reports. MRMIB relied upon experience in managing the HFP and the State and Federal statutes and regulations which are referenced above.

#### **STATEMENTS OF IMPACT AND MANDATE**

- a. The Managed Risk Medical Insurance Board has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.
- b. Statement of Alternatives Considered.

In accordance with Government Code Section 11346.5(a)(12), the Managed Risk Medical Insurance Board has determined that no alternative considered by the Board would be more effective in carrying out the purpose for which the regulations are proposed or would be as effective and less burdensome to affected private persons than the proposed regulations.

c. Statements of Impact on Local Agencies, Private Persons, Businesses and Small Businesses.

There are no non-discretionary costs or new costs to local agency school districts.

There is no impact on California housing costs.

There is no adverse economic impact on California business including the ability of California business to compete in other states. The Healthy Families and Medi-Cal programs impacted by these regulations are for private families. There is a positive impact on private families, who can get earlier access to coverage through the CHDP gateway, and retain coverage longer through the elimination of retroactive disenrollment and retention of coverage during an appeal.

The Board has assessed the impact of these regulatory changes on California businesses, including small businesses. The changes involve individuals who are applying for and receiving health coverage through the HFP. Health, dental, and vision plans may have increased business due to the eligibility time extension provided under these regulations. However, the amount of funds distributed to providers will not be significant enough to either create or eliminate jobs within California, and will not create new businesses or affect the expansion of businesses currently doing business within California.

**AUTHORITY AND REFERENCE:** The law the Board seeks to make specific by this filing is Part 6.2 of Division 2 of the Insurance Code, Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.21, 12693.43, 12693.45, 12693.46, 12693.60, 12693.61, 12693.62, 12693.63, 12693.70, 12693.71, 12693.73, 12693.74, 12693.75, 12693.77, 12693.85, 12693.86, 12693.87, and 12693.89, 12693.91, 12693.98, 12693.105, 12693.615, 12693.755 and 12693.981, Insurance Code and 42 CFR Section 457.1170.

**DOCUMENTS INCORPORATED BY REFERENCE**

No documents were incorporated by reference in these regulations.